I

105TH CONGRESS
1ST SESSION

H. R. 1749

To amend title I of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to improve and clarify accountability for violations with respect to managed care group health plans.

IN THE HOUSE OF REPRESENTATIVES

MAY 22, 1997

Mr. STARK (for himself, Mr. KILDEE, Mrs. LOWEY, Mr. MILLER of California, Mr. FRANK of Massachusetts, Ms. PELOSI, Mr. SANDERS, Mr. TIERNEY, Mr. FROST, Mr. DELLUMS, Ms. CHRISTIAN-GREEN, Mr. LEWIS of Georgia, Mr. DEFAZIO, Mr. WAXMAN, Mr. RANGEL, Mr. KUCINICH, Mr. KLECZKA, Mr. KENNEDY of Rhode Island, Ms. RIVERS, Mr. MCGOVERN, Mr. BERMAN, and Mrs. TAUSCHER) introduced the following bill; which was referred to the Committee on Education and the Workforce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to improve and clarify accountability for violations with respect to managed care group health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Managed Care Plan Accountability Act of 1997''.

SEC. 2. IMPROVEMENTS IN ERISA ENFORCEMENT WITH RESPECT TO MANAGED CARE GROUP HEALTH PLANS.

(a) ADDITIONAL REMEDIES FOR COST-DRIVEN VIOLATIONS OF PLAN TERMS.—

(1) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

''(6)(A) In any case in which a group health plan, or a health insurance issuer offering health insurance coverage in connection with such plan, provides benefits under such plan under managed care, and such plan or issuer fails to provide any such benefit in accordance with the terms of the plan or such coverage, insofar as such failure occurs pursuant to a clinically or medically inappropriate decision or determination resulting from—

''(i) the application of any cost containment technique,

''(ii) any utilization review directed at cost containment, or

''(iii) any other medical care delivery policy decision which restricts the ability of providers of medical care from utilizing their full discretion for treatment of patients,

each specified defendant shall be jointly and severally liable to any participant or beneficiary aggrieved by such failure for actual damages (including compensatory and consequential damages) proximately caused by such failure, and may, in the court's discretion, be liable to such participant or beneficiary for punitive damages.

''(B) For purposes of this paragraph—

''(i) a group health plan, or a health insurance issuer offering health insurance coverage in connection with the plan, provides benefits under 'managed care' if the plan or the issuer—

''(I) provides or arranges for the provision of the benefits to participants and beneficiaries primarily through participating providers of medical care, or

''(II) provides financial incentives (such as variable copayments and deductibles) to induce participants and beneficiaries to obtain the ben-

efits primarily through participating providers of medical care,

or both.

''(ii) The term 'specified defendant' means, in connection with any failure to provide any benefit, a person who is—

''(I) the plan sponsor, or

''(II) a health insurance issuer offering health insurance coverage in connection with the plan,

insofar as an act or failure to act of such person constitutes or contributes to the failure to so provide such benefit.

''(iii) The term 'participating' means, with respect to a provider of medical care in relation to a group health plan or health insurance coverage offered in connection with a group health plan, a provider that furnishes the items and services comprising medical care to participants and beneficiaries under the plan under an agreement with the plan or with a health insurance issuer offering the coverage.

''(iv) The provisions of section 733 apply in the same manner and to the same extent as they apply for purposes of part 7.

''(C) Remedies under this paragraph are in addition to remedies otherwise provided under this section.''.

(2) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(A) in the first sentence, by inserting ''and except for actions under subsection (a)(1)(A) of this section for the relief provided in subsection (c)(6) of this section,'' after ''this section,''; and

(B) in the last sentence, by inserting ''and under subsection (a)(1)(A) of this section for the relief provided in subsection (c)(6) of this section'' after ''this section''.

(b) INDEMNIFICATION FOR LIABILITY OF PROVIDERS BOUND BY PLAN RESTRICTIONS ON MEDICAL COMMUNICATIONS.—Section 502 of such Act (29 U.S.C. 1132) is amended further by adding at the end the following new subsection:

''(n)(1) In any case in which a group health plan, or a health insurance issuer offering health insurance coverage in connection with such plan, provides benefits under such plan under managed care, the plan shall provide for full indemnification of any participating provider of medical care for any liability incurred by such provider for any failure to provide any such benefit in accordance

with the terms of the plan or such coverage, if such failure is the direct result of a plan restriction on medical communications under the plan.

''(2) For purposes of this subsection—

''(A) the term 'plan restriction on medical communications' under a group health plan means a provision of the plan, or of any health insurance coverage offered in connection with the plan, which prohibits, restricts, or interferes with any medical communication as part of—

''(i) a written contract or agreement with a participating provider of medical care,

''(ii) a written statement to a participating provider of medical care, or

''(iii) an oral communication to a participating provider of medical care.

''(B) The term 'medical communication'—

''(i) means any communication made by the provider of medical care—

''(I) regarding the mental or physical health care needs or treatment of a patient and the provisions, terms, or requirements of the group health plan or health insurance coverage or another plan or coverage relating to such needs or treatment, and

"(II) between the provider and a current, former, or prospective patient (or the guardian or legal representative of a patient), between the provider and any employee or representative of the plan or issuer, or between the provider and any employee or representative of any State or Federal authority with responsibility for the licensing or oversight with respect to the plan or issuer; and

"(ii) includes communications concerning—

"(I) any tests, consultations, and treatment options,

"(II) any risks or benefits associated with such tests, consultations, and options,

"(III) variation among any providers of medical care and any institutions providing such services in experience, quality, or outcomes,

"(IV) the basis or standard for the decision of a managed care group health plan, or a health insurance issuer offering health insurance coverage in connection

with such a plan, to authorize or deny particular benefits consisting of medical care,

''(V) the process used by the plan or issuer to determine whether to authorize or deny particular benefits consisting of medical care, and

''(VI) any financial incentives or disincentives provided by the plan or issuer to a provider of medical care that are based on service utilization.

''(C) For purposes of this paragraph, the provisions of subsection (c)(6)(B) apply in the same manner and to the same extent as they apply for purposes of subsection (c)(6), and the provisions of section 733 apply in the same manner and to the same extent as they apply for purposes of part 7.''.

SEC. 3. EXCISE TAX FOR COST-DRIVEN VIOLATIONS OF PLAN TERMS.

(a) IN GENERAL.—Chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter B—Failure To Provide Health Benefits Due to Improper Cost-Driven Delivery Policy Decisions

''Sec. 9811. Failure to provide health benefits due to improper cost-driven delivery policy decisions.

"SEC. 9811. FAILURE TO PROVIDE HEALTH BENEFITS DUE TO IMPROPER COST-DRIVEN DELIVERY POLICY DECISIONS.

''(a) GENERAL RULE.—In the case of a group health coverage to which this section applies, there is a failure to meet the requirements of this chapter if—

''(1) the provider of such coverage fails to provide any benefit in accordance with the terms of the coverage, and

''(2) such failure occurs pursuant to a clinically or medically inappropriate decision or determination resulting from the application of—

''(A) any cost containment technique,

''(B) any utilization review directed at cost containment, or

''(C) any other medical care delivery policy decision which restricts the ability of providers of medical care from utilizing their full discretion for treatment of patients.

''(b) HEALTH COVERAGE PROVIDERS TO WHICH SECTION APPLIES.—This section shall apply to any group health coverage which is provided under managed care.

''(c) DEFINITIONS.—For purposes of this section—

''(1) GROUP HEALTH COVERAGE.—The term 'group health coverage' means—

''(A) coverage under any group health plan, and

''(B) health insurance coverage provided by a health insurance issuer.

''(2) MANAGED CARE.—Group health coverage is provided under managed care if—

''(A) such coverage is provided primarily through participating providers of medical care, or

''(B) the provider of such coverage provides financial incentives (such as variable copayments and deductibles) to induce participants and beneficiaries to obtain the benefits primarily through participating providers of medical care,

or both.

''(3) PROVIDER.—The term 'provider' means—

''(A) the group health plan in the case of coverage described in paragraph (2)(A), and

''(B) the health insurance issuer in the case of coverage described in paragraph (2)(B).

''(4) OTHER DEFINITIONS.—The terms 'group health plan', 'health insurance coverage', and 'health insurance issuer' have the respective meanings given such terms by section 9805.''.

(b) CONFORMING AMENDMENTS.—

(1) Subtitle K of such Code is amended by striking all that precedes section 9801 and inserting the following:

"Subtitle K—Group Health Plan Requirements

"Chapter 100. Group health plan requirements.

"CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

"Subchapter A. Requirements relating to portability, access, and renewability.
"Subchapter B. Failure to provide health benefits due to improper cost-driven delivery policy decisions."

(2) The table of subtitles for such Code is amended by striking the item relating to subtitle K and inserting the following new item:

"Subtitle K. Group health plan requirements."

SEC. 4. EFFECTIVE DATE.

The amendments made by this Act shall apply with respect to plan years beginning after on or after January 1, 1998.

○